AIR FORCE MENTAL HEALTH: THE COMPANY GRADE OFFICER PERSPECTIVE

SQUADRON OFFICER SCHOOL CLASS 13E, TEAM 2

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INTRODUCTION

Bottom line up front…our Airmen are dying and we can't see it! Professional and personal stigma, lack of understanding regarding confidentiality, and failure to educate at the grassroots level (i.e., families) has hindered an otherwise effective program. In 2012, the Air Force noticed a 15.6% increase in suicides from 2011 (from 51 to 59) (Starr B., 2013, online). In June 2013, the Department of Defense (DoD) issued DoD 6490.14, *Defense Suicide Prevention Program* with the requirement that the entire DoD "take substantial efforts to reduce suicide" (DoD 6490.14, 2013, p. 2). With the increase in Air Force suicides and the DoD's focus on effective programs, it is imperative to study the Air Force's resiliency and suicide prevention programs from all perspectives. The following study was conducted by Think Tank Team 2 using a mixed methodology. The team entered the study with the hypothesis that a negative stigma regarding seeking help exists; that the Air Force policy on suicide prevention and resiliency is either unknown or non-existent; and that the current suicide prevention policy does not fully meet its intended goals because it does not reinforce support at the grassroots level.

EXECUTIVE SUMMARY

Team 2 used the findings from a robust literature review, a survey, and a one-on-one interview to test the team's hypothesis, identify existing flaws in Air Force policy, and develop recommendations to improve the Air Force's suicide prevention and resiliency programs. The literature review also includes insight into the academic literature that informed the General Systems Model introduced in the Methodology. Team 2 utilized a qualitative and quantitative methodology to further expand on the data gained from the literature review. Team 2 used a 10 question survey to collect data from the SOS focus group of class 13E. An interview vignette was also conducted to test the results of the survey.

These surveys indicated that the majority of CGO's felt as though they could appropriately respond to an Airman dealing with a mental health issue, but it would not be likely they would seek mental health help themselves. It was identified that the primary reason for not seeking mental health help was the lack of confidentiality and the possibility of being perceived negatively when returning to the workplace.

Team 2's recommendations for Air Force leadership include streamlining current resources available and policies, normalizing mental health programs, adopting a confidential Wingman program and adopting a fourth core value focusing on resiliency. Finally, Team 2 provided areas for further research as a result of this study.

LITERATURE REVIEW

This section provides a comprehensive literature review of DoD policies, service component policies and reports gleaned from the Navy's Task Force Resilient study, a commissioned study from RAND, medical research, and finally Air Force policies and programs. A literature review of the General Systems Model was conducted to inform the methodology of the policy analysis in this paper and is described in detail in the Methodology section of this paper.

a. Department of Defense

In August 2010, the DoD published a study entitled, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives.* This study was conducted by the Task Force on Suicide Prevention, which was established in 2009. The study focused on 10 strategic objectives and recommendations for change and included personal vignettes from actual suicides. The study identified strategic communications that promote life, normalize "help-seeking behaviors" and support DoD suicide prevention strategies were found to be lacking.

There was an identified need to reduce stigmas and overcome military cultural and leadership barriers to seeking help. Finally, there was a need to standardize policies and procedures for suicide prevention (DoD, 2010, online).

Additionally, the study focused on wellness, enhancement and training found that the DoD needed to enhance well-being, mental fitness, life skills and resiliency for military members and their families (DoD, 2010, online). The study showed that the DoD had a need to ensure availability of reliable, high-quality, behavioral healthcare. It further mentioned that military community-based services and local civilian community services should be leveraged to improve care. Professionals providing help needed training to deliver "evidence-based care" for assessment, management, and treatment of suicide-related behaviors. Evidence based care is defined as care which has been clinically proven to be effective. The study found that effective postvention (care following a suicide incident) programs for families, service member, and leaders were needed and currently lacking. Finally, a comprehensive surveillance to identify at-risk personnel to inform prevention was found (DoD, 2010, online).

The final focus area discovered in the study was the surveillance, investigation and research areas of suicide prevention. The study explained there was a need to standardize investigation and reporting of suicides and attempts, and provide for program evaluation components to all DoD programs and initiatives. The report stated that there was a need to incorporate ongoing research into prevention practices to ensure they were updated with evidence-based research in near real-time (DoD, 2010, online).

b. Navy (Task Force Resilient)

The team reviewed the extensive findings from the Navy's TF Resilient Final Report published in April 2013. The study indicated that the Navy had researched suicide in the service

since 1966 and that the Navy's suicide rate was lower than the civilian sector, but had been trending upwards. This is in keeping with the DoD and other service components' impetus for resiliency focus. The TF found that the Navy had a policy on suicide prevention, but that no policy existed for resiliency. The study further found that the primary demographic for suicide was white enlisted males, ages 17-24. Common factors found in this study were the use of alcohol in 35% of cases and sleep deprivation in approximately one-third of cases. Hospital Corpsman and nuclear rates had the highest suicide rates; and the primary location for suicide completion was at the victim's CONUS residence. The TF looked at operations tempo, but found that 80% of the victims had either deployed only once or not at all and that the majority happened 1-2 years after returning from deployment or while in transition (i.e., PCS) (CNO, 2013, p. 1-43).

To evaluate Navy programs, the TF developed an informal framework used for assessing program effectiveness. The framework categorized the Navy's existing programs into three tiers, adapted from the DoD Suicide Prevention Office (DSPO). The Naval Expeditionary Combat Command (NECC) developed a robust internal resiliency program with three interconnected components: Advanced Operational Stress Control (OSC) training to all personnel in supervisory roles, family readiness teams, and the embedded Mental Health Program (eMHP). The cornerstone of the program is the eMHP that provides 10 embedded mental health providers and allows NECC members 24/7 access to counseling, checkups, and resiliency screening. This program has resulted in a 95% total satisfaction rating, 99% recommendation to others rating, and 96% of sailors stating it has helped them better deal with issues.

c. Army

The Army Suicide Prevention Program was updated most recently by the 2009 Army Suicide Prevention Task Force. Implementation focuses on installation commanders appointing committees to focus on local efforts. The Army program seeks to reduce stigma, increase awareness and improve intervention skills (Ramchand et. al., 2011). The Army was found to use resiliency throughout the entire training continuum, not just in suicide prevention. The Army integrates other self-help programs to reduce or eliminate suicides such as Sexual Assault Prevention Response, bullying/hazing, substance abuse, domestic violence and stigma/barrier training. The Army also leverages a large array of online resources for its members (CNO,2013, p. 1-43).

d. Marines

The Marines utilize an operational stress control program that attempts to identify and mitigate stress before self-destructive behavior begins (CNO, 2013, p.1-43). The Marine program focuses on health promotion, life skills, leadership, crisis intervention and risk management, counseling and treatment, postvention services, and casualty reporting and trend analysis (Ramchand, R. et.al., 2011). The Marines run the Families OverComing Over Stress (FOCUS) program for families, couples, and children of Marines to teach resiliency to the entire member support network. They have a crisis hotline and teach small classroom curriculum centered on never leaving a Marine behind (CNO, 2013, p.1-43). Marine Corps Order (MCO) 1720.2 allows Marines to earn a citation for seeking peer-to-peer help or preventing suicide by another Marine (MCO 1720.2). Finally, the USMC case management system is aligned across multiple systems to ensure accurate data collection (CNO, 2013, p.1-43).

e. RAND

Team 2 evaluated the 2011 RAND study entitled, *The War Within: Preventing Suicide in the U.S. Military*. Chapter 5 of the study was used to inform the service component policy reviews. Chapter 6 provided the following six recommendations for a comprehensive suicide-prevention program: 1) Raising awareness and promoting self-care; 2) Identification of high risk individuals; 3) Facilitating access to quality care; 4) Providing quality care; 5) Restricting access to lethal means; 6) Responding appropriately to suicides and suicide attempts. RAND also found that the majority of suicides were not combat related (Ramchand, R. et.al, 2011).

f. Medical Reports

The New England Journal of Medicine produced a study in 2004 that looked into four U.S. combat infantry units before and after their deployments to Iraq and Afghanistan. The report showed there was a significant risk to mental health as a result of deployments. The subjects of the report stated that they found barriers to receiving mental health services while deployed and mentioned stigma as a factor considered before requesting help. The study found that "concern about stigmas was disproportionately greatest amongst those most in need of help from mental health services." The study recommended increasing allocation and availability of mental health services, providing confidential counseling means, improving PTSD screening, and the need for a program to reduce the stigma associated with seeking care (Hoge, C. et.al., 2004, p. 13-22).

Additionally, Military Medicine published an article in 2012 entitled, *Factors Affecting Mental Health Service Utilization Among Deployed Military Personnel*. The study compared characteristics of military members using mental health services in deployed and non-deployed settings, communications between commanders and providers, and how mental health services

affected military duties. The study found that command communication degraded during deployments and that duty restrictions were higher in deployed environments. The study also discovered that self-referral reduced the likelihood of duty restrictions or command engagement, with only 12% of self-referrals resulting in duty restrictions. The study concluded that the fear of command retribution for seeking mental health treatment was seemingly unfounded, and that providers and commanders should de-emphasize the negative career impact of seeking help (Christensen, B., et.al., 2012, p278-283).

g. Air Force

A definitive Air Force resiliency policy does not currently exist, but a draft is being created at the time of this writing. Air Force suicide prevention policies and guidance are derived from seven separate source documents that collectively detail the responsibilities of individuals, commanders, providers, and first responders. The governing policy for suicide prevention in the Air Force is Air Force Instruction (AFI) 90-505, *Suicide Prevention Program*, dated 10 August 2012. AFI 90-505 is an addition to the findings outlined by the AF IPT in AFPAM 44-160. AFI 90-505 recommends a community-based approach to reduce suicide by using the Wingman concept and the chain of command. It also urges leaders to prioritize suicide prevention and foster a culture that strengthens social support. Policies are executed at the installation level by the Community Action Information Board (CAIB). According to AFI 90-505, the chair of the AF CAIB, AF/CVA, is responsible for promoting a healthy environment that encourages help-seeking behaviors and Wingman intervention. The Air Force Surgeon General is the lead for the Air Force's Suicide Prevention Program. AF/A1 is identified as the lead for AF policy and guidance regarding education and training. AETC is tasked to work with A1 to ensure suicide prevention training is incorporated into initial training for accessions, tech

school curricula, continuing education programs, etc. AFI 90-501, *Community Action Information Board and Integrated Delivery System,* briefly mentions these roles, but does not provide specific guidance regarding how these roles and responsibilities are to be executed.

The Air Force Suicide Prevention Program (AFSPP) is considered to be very successful by other military services as well as by civilian industries. It is the only military program that boasts a realized reduction in suicides from 2002-2011. It was modeled after the efforts of the Jed Foundation, an organization that reaches out to college students at risk for suicide (CNO, 2013, p. 1-43).

The Air Force has prepared an easy-to-reference manual known as the *Airman's Guide for Assisting Personnel in Distress* to empower airmen with tools they can use when helping others. Two versions of this guidance exist – one is specifically for commanders and the other is for Wingmen. Both versions of the manual briefly outline common symptoms of distress, individual roles in overcoming the stigma associated with seeking help, and actions airmen should take to assist others in distress. The last several pages of each guide highlight and explain the various military and civilian programs that are available to airmen and their dependents.

AFI 44-153 discusses Traumatic Stress Response (TSR), which is a process identified by the Air Force that allows leaders to engage with TSR teams to provide services to individuals or groups who may have been exposed to potentially traumatic events. They are responsible for creating standard operating procedures to provide assistance to airmen who have witnessed or were involved in traumatic situations like air or ground mishaps, a hostage situation, or a search and rescue operation.

Patient-doctor confidentiality is outlined in AFI 44-109, *Mental Health, Confidentiality, and Military Law*. This guidance outline procedures regarding commanders' and law

enforcement's obligations to mental health regarding patient confidentiality. Unless there is a legitimate need for information and the persons or agencies requesting information are authorized by law or regulation, patient/psychotherapist communications are confidential. However, mental health is authorized to break confidentiality if a therapist believes that a patient poses a risk to themselves, dependents, military property, classified information, or mission accomplishment.

METHODOLOGY

Team 2 mixed methodology included a literature review of component service suicide and resiliency policies and academic articles, a utilization of the General Systems Model for assessing public policy in regards to the current Air Force policy, and a Likert-scaled survey and interviews with CGOs. The literature review was conducted initially in order to inform the survey and interview questions and to provide the policy knowledge required to inform the inputs, conversion and outputs of the General Systems Model.

a. Survey

The survey was developed by the entire Think Tank team of 24 students working with Air University PhD Professors specializing in Psychology and Communication to capture the CGO's perspective. The survey was reviewed and approved by the Headquarters AU, Human Research Protection Program. Questions were developed by the teams based on information gleaned from the literature reviews. The survey was submitted to an entire SOS class focus group of 742 students (a breakdown of the class demographics can be found at Attachment 3). The Team received 654 responses out of the class of 742 CGOs. The demographics of the respondents were not captured due to AU IRB Human Research restrictions. The survey is provided at Attachment 1 to this paper.

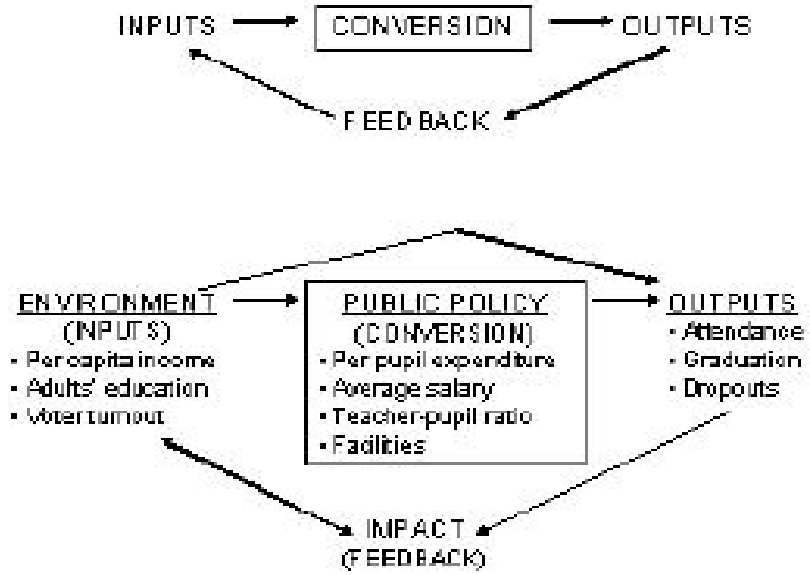
c. Vignette Interview

To provide a qualitative test to the data received from the surveys and to inform the inputs and impacts of the General Systems Model, interviews were conducted with 26 CGOs chosen at random. These interviews were centered on a theoretical scenario-based vignette to support or contend data received and to find what parts of the Air Force mission culture or values influence Airmen to seek help. The vignetteand questions are provided at Attachment 2 to this paper.

c. General Systems Model

The team used the General Systems Model to assess the effectiveness of the current Air Force Policy. Since no policy on resiliency exists the team reviewed the Air Force policy on suicide prevention. The systems model is the most widely used conceptual framework in the policy sciences (Rendon R. and Synder K., 2008, p.310-333). The model considers the intended goals related to the policy, determines the environmental inputs that lead to the policy, the policy standards themselves (known as the conversion), the observed outputs from the implementation of the policy and the resultant impact/feedback of these outputs and how they inform the future environmental inputs (see below) (Rendon, R. and Snyder, K., 2008, p310-333):

Figure 3: General Systems Model

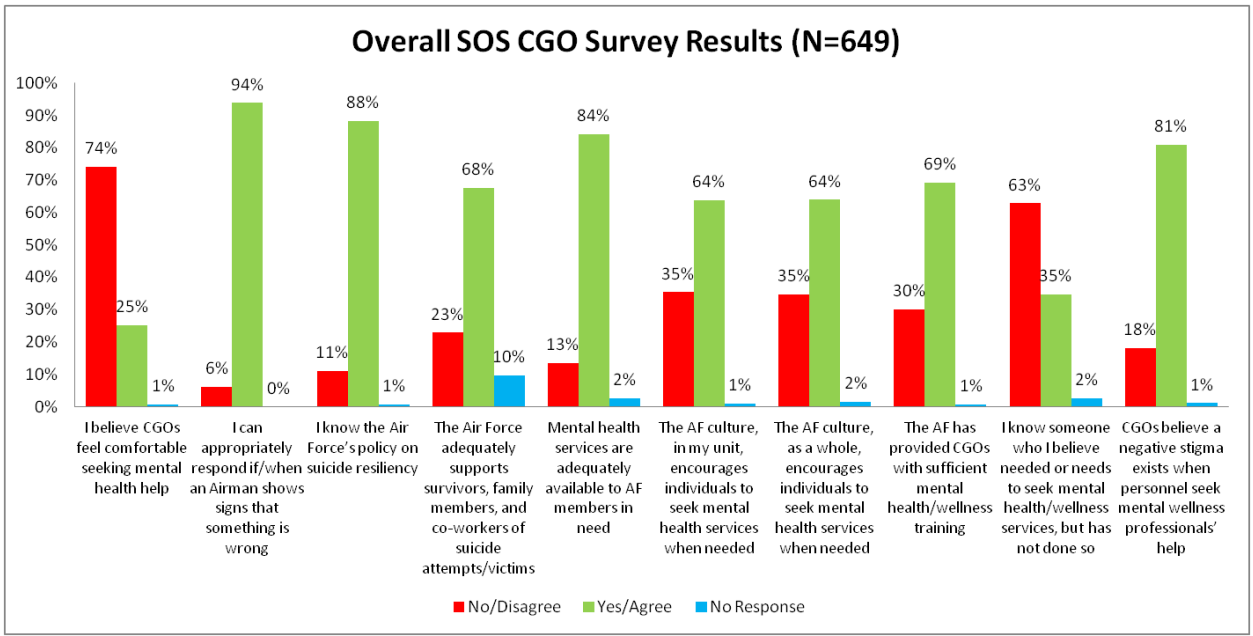


FINDINGS

a. Survey

The survey was provided to SOS class 13E consisting of 742 students from a variety of AFSCs with an average age of 30 years old. The majority of the Officers surveyed were male, line officers of the Air Force CGOs but included others of different sex, race and AFSCs. These demographics are informed directly by the statistics from the SOS command section. Responses were received from 654 CGOs. This provided a high response rate of 88% of CGOs surveyed. The first question on the survey required the CGOs to identify any special status or experience to inform the survey. This included PRP, SCI, Flight status, and having deployed. The results showed that 68% or 441 of the respondents have deployed, 52% or 340 of the respondents have an SCI clearance, 8% or 54 are on PRP status and 48% or 310 of the respondents are on flight status.

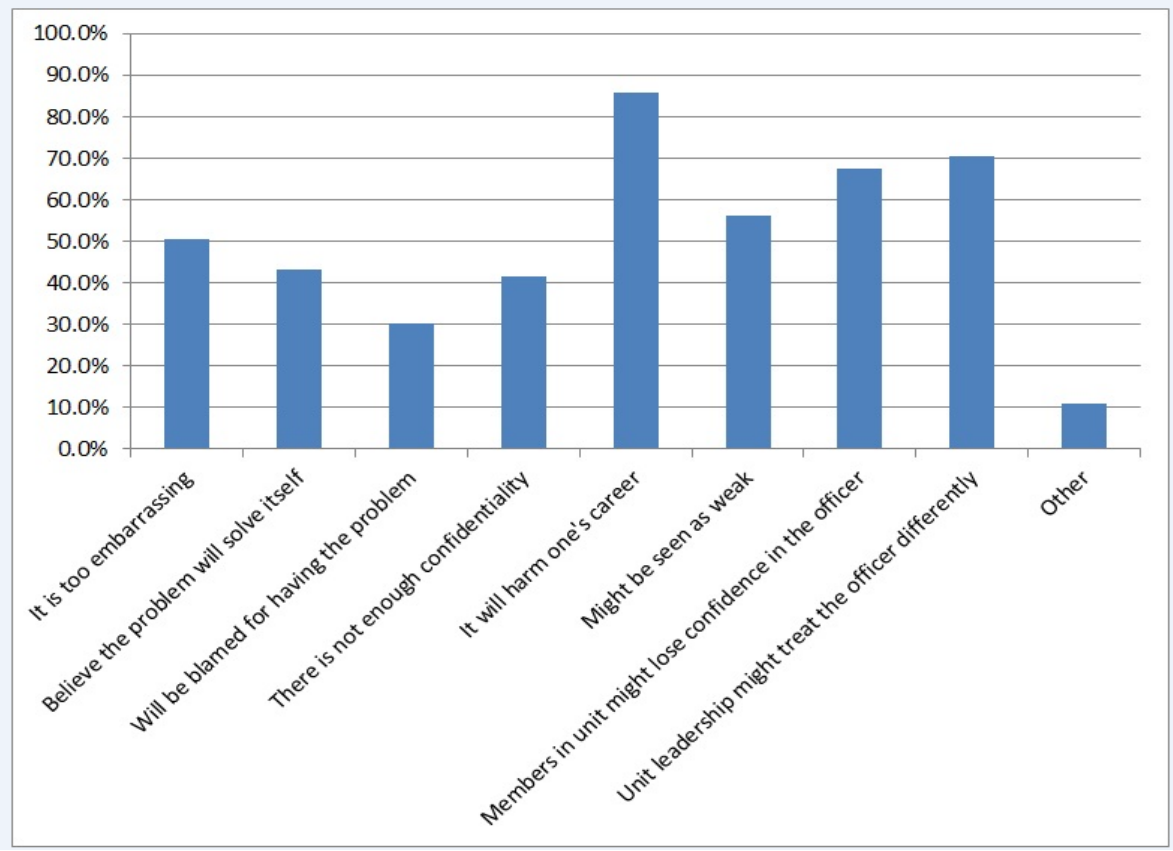
Next the survey asked ten specific questions regarding the respondent's beliefs in four variances of agreement ranging from 1 to 4 (1=Strongly Disagree, 2=Disagree, 3=Agree, 4=Strongly Agree). This Likert scale was converted to a No/Disagree equal to all responses in the range of 1-2 and Yes/Agree for all responses ranging from 3-4. The following table shows the results of the survey responses received from 649 CGOs: Figure 4: Survey Responses



The survey results brought up many interesting and unexpected trends. Specifically, almost all respondents (94%) indicated that they could appropriately respond to a subordinate, yet only 25% responded that CGOs feel comfortable seeking health. This indicates that surveyed officers are very comfortable seeking help for others but not for themselves. This points to the idea that there is some type barrier preventing CGOs from seeking help to deal with mental health issues. Also, despite the high numbers of those that feel comfortable responding, significantly less (69%) feel that the AF has provided adequate training.

Following the ten questions were specific survey questions regarding perceptions CGOs have that would inhibit motivation to seek mental health/wellness services. These responses were used to determine causes of stigma among the CGOs surveyed. Only 507 responses were received and calculated for these questions. The following chart represents the responses received:

Figure 5: Stigmas/Perceptions



Respondents were allowed to check more than one response. The survey shows that the top five perceived stigmas by the participants were 1) Harmful to a career at 85.8%, 2) Unit leaders might treat the officer differently at 70.4%, 3) Others may lose confidence in the officer at 67.5%, 4) They might be seen as week at 56.2% and 5) it is too embarrassing at 50.5%. These results indicate that the barrier to CGOs seeking help on their own stems from the stigmas surrounding mental health issues.

Finally the survey respondents were asked questions regarding their awareness of four resources; Mental Health, chaplain, Military OneSource and Military Family Life Counselors (MFLC). They were also asked to categorize these four resources as either confidential or not confidential. As with the stigma questions only 507 of the 742 CGO responses were received and calculated. The following table shows the level of awareness and rating of confidentiality the CGOs responded with:

Table 1: CGO Awareness and Confidentiality Ratings

Percentage of CGOs Answering Survey Questions (of 507 surveyed)				
	Mental Health	Chaplain	Military One Source	MFLC
Aware	92.3%	94.7%	79.5%	73.2%
Not Aware	6.5%	4.1%	18.5%	24.7%
No Answer	1.2%	1.2%	2.0%	2.2%
	Mental Health	Chaplain	Military One Source	MFLC
Confidential	33.5%	85.6%	31.2%	36.3%
Not Confidential	51.5%	6.3%	48.1%	40.2%
No Answer	15.0%	8.1%	20.7%	23.5%

The respondents overwhelmingly chose the chaplain and Mental Health as the top sources of which they were aware (94.7% and 92.3% respectively). However, the chaplain was the only source with a greater than 50% categorization of Confidential at 85.6%.

b. Vignette Interview

The next step in the research involved members of Team 2 conducting oral interviews with 26 CGOs at both SOS and the Air Force at large using the theoretical scenario vignette found in Attachment 2 of this paper. Interviewees were given a theoretical scenario in which they are supervising a young airman returning from a violent deployment that is displaying unordinary tendencies, relationship problems at home, and has become despondent and aggressive. Once the scenario was read to the interviewees each was asked a battery of six questions listed below with the common themes derived from the responses:

Question 1: What resources would you recommend to your airman to help him cope with his difficulties?

The overwhelming majority of interviewees recommended the chaplain as their first resource, many citing the benefits of confidentiality. Other resources with multiple citations were peers/friends and the Airmen and Family Readiness Center. The response of "chaplain" correlates to the literature review findings and following interview questions that show confidentiality to be a primary concern among Airmen from a CGO perspective. This is further supported by the 86.5% of CGOs surveyed who understood counseling with chaplain to be confidential. Confidentiality was found to be a primary perceived stigma among 41.4% of CGOs surveyed.

Question 2: How comfortable do you feel personally helping your Airman navigate his stress?

The majority of interviewees stated that they were comfortable with helping the airman with varying degrees such as "very" or "quite" comfortable. While 94% of CGOs surveyed who

responded that they felt they could appropriately respond to an Airman showing signs that "something is wrong".

Question 3: How likely is it that your Airman will seek professional help on his own?

The majority of interviewees made statements ranging from "not very" to "very unlikely," with most leaning towards the concept that the Airman would not seek help on their own. This response is informed by the 85.8% of CGOs who felt that the stigma lies with affecting one's career, which was AFSC specific. Further, the survey found that 74% of CGOs did not believe that CGOs feel comfortable seeking mental health help.

Question 4: What personal or professional barriers do you think may prevent him from seeking assistance?

Interviewees primarily stated that stigma and fear of job impact were the primary barriers to seeking assistance. Others mentioned the lack of understanding surrounding the degree to which mental health assistance was confidential. This question was later expounded upon by most interviewees in Question 5 below.

Question 5: Why do you think these barriers may prevent him from seeking assistance?

Many responses were received but the team found patterns in responses such as stigma, job impact, teammate's perception of them, loss of confidence, retribution and response from leadership. The survey results found that 85.8% of CGOs thought it would harm their career to seek help; 70.4% thought leadership would treat them differently; 67.5% thought unit members would lose confidence in them for seeking help; and 56.2% thought they might be perceived as weak.

Question 6: If you were CSAF for a day, what changes would you make to existing Air Force programs to make them more effective? Why?

Many of the respondents answered the question with "none" and felt that the Air Force had adequate programs available. Others mentioned that there needed to be an increase in education over the confidentiality of each program, the need to include and teach service member families regarding resiliency, the need to make training and interactions more personable at all levels and felt it was necessary to embed mental health professionals at the unit level. This is supported by the best practices found within NECC in the literature review and is supported by the survey data which found that 35% of CGOs do not believe the Air Force as a whole or at the unit level encourage seeking mental health, 30% do not believe the Air Force adequately trains CGOs on mental health and wellness and 23% still believe that the Air Force does not adequately support survivors, family members, and co-workers of suicide victims.

PERSPECTIVES AND RECOMMENDATIONS

From a CGO perspective, assessment of the Air Force policy toward suicide shows that it is failing to control the rate of growth for suicides, has failed to realize that a particular demographic is at risk, has not reduced the stigma, has too many programs for addressing mental health without focusing on those that are considered the most and does not focus strongly enough on resiliency as no such policy exists. Further, there seems to be an issue with Air Force Culture in seeking mental health support that is primarily caused by fear of job impact or perception impacts from co-workers and leadership.

The Team considered all of the policies, best practices and themes in the course of this research in developing its perspectives and recommendations. The Team found the following as an initial assessment from the overall study:

CGO Perspective	**Initial Recommendations**
● The Air Force does not "normalize" help seeking behavior in regards to mental health.	● Make mental health visits mandatory on a recurring basis (suggest annually, pre/post deployment, and pre/post PCS). This will facilitate in reducing stigma and encouraging communication between provider and the command. ● Consider adding to the Core Values a value relating, more or less, that "Every Airmen Counts." If all Airmen are encouraged to find their purpose beyond their behavior towards the AF they can have the resilience to recover or adjust when they make a mistake, start to give too much of themselves to their detriment or fall short of excellence, even when trying. Usefulness and belongingness are two of the three primary shields to suicide. If Airmen are encouraged to seek a sense of usefulness and belongingness outside of their primary mission they have the tools to remain resilient.
● The Air Force does not address resiliency issues at a "grass-roots" personal level with Airmen and their families. The Air Force has plenty of available programs but they are not focused on a personal level in a standardized fashion. This is the level where risks are most identifiable.	● The Air Force could hold "Human Factor Boards" (similar to the Naval aviation community) at the Squadron and Flight (depending on unit size) level to ensure leaders assess their Airman on a personal level at least annually via OPR or mid-term feedback. ● Air Force must begin to extend education to family members and friends on resiliency, total fitness, signs and risk factors associated with suicide and means to seek help and report concerns. ● The Air Force should consider updating a social media site such as Facebook with local mental health program information so that family members and friends can readily access up to date material and reporting instructions developed from evidence-based research. ● Either make face-to-face counseling mandatory for all Tiers of the AFSPP or

	recognize the need to place all young, enlisted white males in the Tier 2 group and supervisors of this demographic in Tier 3 training based on the preponderance of consistent evidence to that demographic as "high-risk".
● Airmen do not feel that they can confidentially obtain assistance outside of a Chaplain.	● Institute an anonymous "Wingman" program whereby members can volunteer to serve as an informal counselors by signing up at mental health. The anonymous Wingman can be assigned from separate bases within the Command to protect anonymity. ● Per the findings from the CGO's Perspective survey, consider making the Chaplaincy Corp the lead for Air Force Resiliency. They are perceived as having the highest awareness rating and confidentiality rating and personal interviews found them to be the first resource recommended by most CGOs.
● There are plenty of mental health resources for Airmen. There lacks a centralized and standardized way to educate, and refer Airmen on ways to seek help and the reciprocity inherent in seeking such care.	● Streamline the Air Force guidance on suicide from seven separate source documents to one, and include resiliency in concise document with supporting media and a governing body. ● The Air Force should teach resiliency and suicide prevention reporting methods at all levels of accessions and PME to include the utilization of this study.

Team 2 decided that the final recommendations needed to be actionable in a way that considered a proper tradeoff between impact and resources to implement (including time as a resource). Team 2 categorized these recommendations into two categories, near-term and long-term. Both categories deliver high-impact over a varying amount of time:

Near-term:

1) Standardize Policy

The Air Force should standardize and complete its policy on resiliency to ensure it aligns with current suicide prevention policies, evidence-based research findings, and is instituted and centralized in one comprehensive format and location. This action is currently in the works by the Air Force, but needs to ensure it is communicated to the broader Air Force in a succinct and standardized fashion to ensure it is not lost in the multitude of currently circulating policy updates and emails from leadership. This recommendation already has resources assigned and considers the manner of policy delivery as important as the policy itself.

2) One-stop Shop Resiliency Portal

In keeping with the previous recommendation, the Air Force should ensure its polices, procedures, resources for recognizing and reporting risks and postvention support are made available in one location. The Team recommends that the Air Force stand up a website devoted to Air Force well-being and resiliency and allow for outside access by family and friends of its members. The site should centralize all current policy and the most up-to-date, evidence-based research on resiliency and mental health. This portal should provide a matrix showing available resources and define the level of confidentiality availed by each. This definition of confidentiality is a primary concern based on our research and may encourage maximum involvement from our Airmen. The resources required include a webmaster, coordination with the Air Force Surgeon General, and mental health community, and participation from Air Force Force Support Squadrons at each installation. Further coordination may be required from other agencies not as yet identified. However, this recommendation appears to require a medium level

of resources with at least a medium level of impact to the Airman and their families at the grass-roots level, while maintaining optimum confidentiality.

3) Insert Resiliency Education/Training at All Levels of Accession and PME

Air Force leadership should mandate the already established "Front Line Supervisor" Training at each accession point and all levels of PME to institute initial competencies in resiliency as well as provide for refresher training at gradient levels of career progression. In fact, the results of this research paper could be utilized as study aids for Air Force PME. This recommendation would require coordination from Air Education and Training Command, AU, ROTC detachments, Air Force Academy, and base level PME sources (i.e. Airman Leadership School) to be properly instituted. This recommendation requires minimal resources and can be implemented immediately using existing training.

Long-term:

1) Anonymous Wingman

Another recommendation offered by Team 2 is the idea to institute an anonymous "Wingman" program whereby members can volunteer to serve as an informal "Wingman" by signing up at mental health. Mental health can provide contact information to a database that can be pulled from to assign anonymous "Wingmen" to members who need someone to talk to but do not want to risk the stigma to speaking to members of their unit. The anonymous Wingman can be assigned from separate bases within the Command to protect anonymity. This plays directly into the previously proven Airman's desire for confidentiality in reporting mental health issues. It further allows Airmen to connect at a relational level to members they can relate to. Military OneSource is a current resource that allows for confidentiality but does not necessarily marry up Airmen to peers or other Airmen that can relate to their issues. There is a concern for individual

indemnity that must be considered when allowing anonymous "Wingmen" to perform their duties. Training would be required from the Air Force mental health community and judge advocate general's offices on what could be said by these informal counselors. However, the personal connection and attention that could be garnered from such a program could drastically alter culture, stigma, and access to care. All three of these issues are paramount in the Air Force's desire to improve its resiliency and suicide prevention programs. Due to the outstanding questions surrounding this recommendation and the need to develop a database and network of participants it is recommended as a long-term goal for improving Air Force mental health programs by Team 2.

2) Air Force Core Value Addition

The Team recommends that the Air Force consider adding to its core values the value of "Every Airmen Counts". The intent is to show that every Airman is valuable in and of themselves. Each Airman must find and harness their personal purpose to be excellent in all they do. The Air Force has continually done "more with less" on the backs of exceptional Airmen. Encouraging Airman to understand their personal purpose aligns with resiliency principles of usefulness and belongingness. This recommendation could be implemented immediately with the Air University (AU) LeMay Center for Doctrine as the lead agency. Documents such as the "Little Blue Book" would require updates but would require minimal resource expenditures compared to alternative courses of action. This action may seem like a "soft" improvement but, in an era filled with policies and procedures, a cultural change is needed. If SOS has taught the team nothing, it is that culture cannot change unless values and doctrine are involved in that change.

3) Normalize Mental Health Care in the Air Force

In the long-term the Air Force should consider making mental health visits mandatory on a recurring basis (suggest annually, pre/post deployment, and pre/post PCS). This will facilitate in reducing stigma and encouraging communication between provider and the command. This could include embedding mental health care providers in units (such as the NECC mentioned in the Literature Review) or providing mental health "extender" training to unit members to act as third party counselors to members of their particular unit. This program would require a long-term commitment to change the culture of seeking help in the Air Force in order to "normalize" it and may require the addition of many new mental health resources. These resources may require coordination from the Air Force A1, Manpower office filtered to all level of the Air Force's Major Commands in order to properly staff, facilitate and train these individuals. This recommendation is resource heavy but has a large impact as it would aid in reducing stigma, which has been shown to be a primary barrier through our research, and provide "grass-roots" personal care to our Airmen.

The Team recommends the following as *Areas for Further Research* in regards to Air Force Suicide Prevention and Resiliency:

1) A study should be conducted to find why the majority of suicides in the DoD and Civilian sector occur in white, enlisted males.

2) Research into effective mentoring for Millennials may prove useful to ensure contemporary resiliency policies are kept.

3) The Air Force should consider a study for assessing the effectiveness of their program by utilizing a framework similar to the informal framework developed by the Navy's TF Resilient to

include: *Alignment and Leadership, Policies and Processes, Resources, Training and Support, Metrics and Measures,* and *Communications and Messaging.*

4) The Air Force should assess whether it has adequate mental health providers, counselors and chaplains to meet the needs of an effective program.

CONCLUSION

Team 2 entered the study with the hypothesis that a negative stigma regarding seeking help exists in the Air Force; that the Air Force policy on suicide prevention and resiliency is either unknown or non-existent and that the current policy on suicide prevention is ineffective based on its intended goals. Team 2 discovered that themes regarding stigma, access to care, personal well-being, quality of care, the need for total team training (to include families), the need to standardize care, the need to keep programs up to date with evidence-based data, the need to centralize data, risk factors, and the need to communicate at all levels were consistent themes from the literature review, the surveys and the interviews. The team concluded that, from a CGO perspective: 1) there is a stigma in the Air Force regarding seeking mental health, 2) the policy regarding suicide prevention and resiliency does not hold up to an academic assessment of effectiveness, and 3) the current Air Force culture does not promote individuals seeking help. The current Air Force policy does not result in impacts that support the policies intended goals. There is a resiliency policy on the horizon, but the positive effects of such a program remains to be seen. The Air Force must ensure it reviews policies on a recurring basis considering tools such as the General Systems Model to provide a "vector-check" between intended goals of the policy and realized impacts.

Attachment 1: Think Tank Survey

This survey is intended to gather your opinions about CGOs willingness to use Mental Health services provided by the Air Force. Your participation in the survey is voluntary but will help leadership to ensure Airmen are willing to access the help they may need and support others in doing so.

Demographic Data (Check all that apply):

Flight Status PRP SCI I have deployed

Using the following scale, please rate your level of agreement with the following statements:
1 - Strongly Disagree 2 - Disagree 3 - Agree 4 - Strongly Agree

- I believe CGOs feel comfortable seeking mental/behavioral health.
  1 2 3 4
- I can appropriately respond if/when an Airman shows signs that something is wrong.
  1 2 3 4
- I know the Air Force's policy on suicide resiliency.
  1 2 3 4
- The Air Force adequately supports survivors, family members, and co-workers of suicide attempts/victims.
  1 2 3 4
- Mental health services are adequately available to AF members in need.
  1 2 3 4
- The AF culture, in my unit, encourages individuals to seek mental health services when needed.
  1 2 3 4
- The AF culture, as a whole, encourages individuals to seek mental health services when needed.
  1 2 3 4
- The AF has provided CGOs with sufficient mental health/wellness training.
  1. 2 3 4
- I know someone who I believe needed or needs to seek mental health/wellness services, but has not done so.
  1 2 3 4
- CGOs believe a negative stigma exists when personnel seek mental wellness professionals' help.
  1 2 3 4

In 3 words, describe the generic individual that seeks mental health services:

_____ _____ _____

Check any perceptions CGOs hold that would inhibit motivation to seek mental health/wellness services:

It is too embarrassing Believe the problem will solve itself Will be blamed for having the problem

There is not enough confidentiality It will harm one's career Might be seen as weak

Members of the unit might lose confidence in the officer

Unit leadership might treat the officer differently Other reasons not listed

_____

Are you aware of the following services? Please indicate (circle) whether they are confidential or not:

Mental Health Office:	Yes	No	Confidential	Not Confidential
Chaplain:	Yes	No	Confidential	Not Confidential
Military One Source:	Yes	No	Confidential	Not Confidential
Military Family Life Counselors:	Yes	No	Confidential	Not Confidential

Attachment 2: Team 2 Vignette Interview

You are returning to work along with several members of your unit after a six month deployment to Afghanistan and your subsequent recuperation leave. Morale was low and anxiety was high near the end of the deployment. Your unit encountered several unexpected and hazardous situations while deployed that stressed your personnel beyond their training. Your personnel have been exposed to insurgent attacks and the deaths of unit members.

As you resume your normal duties, you notice one of your best airmen is not behaving normally. He is making several small mistakes that are out of character. He is usually the life of team activities, but he now seems despondent at group gatherings. He has been irritable lately, and he has lashed out at some of his closest friends.

You suspect your airman may be experiencing post-traumatic stress. Based on his account, you believe that most of his stress stems from his personal reintegration at home and difficulty in his marriage. He told you that he has been fighting a lot with his wife and he is having trouble figuring out his role in their relationship. He also feels awkward around his young daughter and he sometimes withdraws from his family in favor of personal time. He is reluctant to offer additional information, and when he does, his statements are very vague.

Using your previous professional experience as a frame of reference, please answer the following questions:

1. What resources would you recommend to your airman to help him cope with his difficulties?
2. How comfortable do you feel personally helping your airman navigate his stress?
3. How likely is it that your airman will seek professional help on his own?
4. What personal or professional barriers do you think may prevent him from seeking assistance?
5. Why do you think these barriers may prevent him from seeking assistance?
6. If you were CSAF for a day, what changes would you make to existing Air Force programs to make them more effective? Why?

Attachment 3: Survey Demographics

Demographic Statistics by Class for SOS Class 13E

Start: 2013-08-12 **Grad:** 2013-10-04

Note: 694 out of **742** students have updated/confirmed their personal information.
Please take this into consideration when viewing the statistics.

Summary	Gender	Married	SOS by Correspondence 622 Attended ASBC 542	Race					
Class size: 742 Avg age: 30		M: 612 F: 130		Y: 498 Unknown: 3 N: 241			White: 607 African American: 56 Asian: 29 Multi: 10 Unknown: 34 American Indian: 1 Hawaiian/Pacific: 5		
				Accompanied 89					
Education	Service Compone	Commissioning Source	MAJCOM	AFSC Breakdown					

	nt								
Masters:	318	Civilian:	2	USAFA:	172	ACC:	158	Acquisitions/Finance:	93
Bachelors:	369	ANG:	21	OTS-COT:	25	USAFA:	4		11
Registered Nurse:	4	AF Active:	699	ROTC:	369	PACAF:	51	Bomber:	4
Unknown:	34	AFRES:	20	AMS:	41	AFCEE:	1	Chaplain Corps:	29
Juris Doctorate:	8			Unknown:	3	AETC:	82	Communications:	34
Other:	9			OTS-BOT:	109	AFELM:	1	Fighter:	14
				Other:	23	AFDW:	5	Helicopter:	39
						HAF:	1	Intel:	9
						AFGSC:	52	JAG Corps:	45
						AFRC:	11	Logistics/Mx:	42
						AFMC:	56	Medical:	14
						AMC:	113	Missing/Invalid:	104
						AFSOC:	54	Mobility:	139
						----------:	13	Operations (other):	61
						OSD (AFELM):	1	Pilot (other):	19
						AFSPC:	58	Pilot (RPA):	24
						AFOTEC:	2	Space/Missile:	6
						AFOSI:	3	Special Duty:	4
						AFCAA:	1	Special	45
						AFMSA:	1	Investigations:	4
						UNKNOWN:	17	Support:	2
						AFPAA:	1	Weather:	
						AFELM USSOUTHCOM:	1	All Others:	
						AIA:	1		55
						AFPC:	2		
						USAFE:	39	NON-LINE TOTAL:	
						AFISRA:	13		

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